## **Impaired Practitioner Program of the Impaired Practitioners Review Committee**

QUARTERLY REPORT

Department of Public Health
Professional Licensure
Lucas State Office Pldg 5th Flor

For Participant Licensee

Professional Licensure Lucas State Office Bldg., 5th Floor, 321 E. 12th Street Des Moines, Iowa 50319-0075

Quarterly reports are due January 20<sup>th</sup>, April 20<sup>th</sup>, July 20<sup>th</sup> and October 20th

313/281-4830	April 20 , July 20 and October 20th		
Licensee Name:	Employer:		
Address:	Work Phone:		
Home Phone:			
Cell:	☐ Check if any of the information provided has changed since last reported.		
E-Mail:			
Does your contract require your med	eting with a		
<u>Psychiatrist</u> :  ☐ Yes ☐ No	If yes, please list meeting dates since last report:		
Therapist/Aftercare Provider:  ☐ Yes ☐ No	If yes, please list meeting dates since last report:		
Worksite Monitor:	$\square$ No		
- · ·	itor be another professionally licensed aily contact unless otherwise approved		
Please provide <u>detailed</u> information below. Note any significant changes or events since your last report. If you need additional space, please feel free to use the back of this sheet or attach additional sheets. Please remember that any changes to your Contract/Recovery Program Description must have prior approval of the IPRC.			
Since the last quarterly report have you:			
	Been arrested, charged with or convicted of any violation of federal or state statutes or city or county ordinances, or been disciplined by a state licensing agency or board?		
Yes - Please explain:			
☐ No			
2. Been arrested, charged or convicte	ed of any federal or state law pertaining to furnishing or using of narcotics or drugs?		
Yes - Please explain:			
□No			

Pra rep mis	I hereby submit this Quarterly Report as specified in my Recovery Contract for the I Practitioners Review Committee. I declare under penalty of perjury under the laws of report in its entirety and know its contents and that all statements provided are misstatements, false information, or omissions of material fact may be cause for a reporformal disciplinary action.	true in every respect, and I understand that
8.	8. Please describe how you feel your recovery/rehabilitation program is pro- issues, events, changes, etc. that have assisted or posed any obstacle to your	
	□ No	
	Yes - Please explain:	
7.	7. Complied with each condition of your Recovery Contract?	
	□ No	
	Yes - Please explain:	
6.	6. Had any problems securing or maintaining employment or hospital privileg	es?
	□ No	
	Yes - Please explain:	
5.	5. Consumed any alcohol?	
	□ No	
	Yes - Please explain:	
4.	4. Taken or used any controlled or prescription drugs?	
	□ No	
	Yes - Please explain	
3.	3. Been sanctioned by a hospital, health care facility, or insurer?	